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The Evolution of the Military Health Care System: Changes in Public Law and DOD Regulations

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(U) The military health care system has two missions. The first is the readiness mission to provide care for U.S. forces who become sick or injured during military engagements. The second is the peacetime mission, which includes maintaining the health of U.S. military personnel and supporting the provision of the military health care benefit to active duty dependents, retirees and their dependents, and survivors. This paper focuses on the legislative and regulatory evolution of this second mission and the costs associated with program change.

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Contents

Summary

The dual mission of the defense health care system involves maintaining the readiness of the medical branches of the armed forces to care for wartime casualties and also providing for the peacetime health care needs of active duty military, their dependents, retirees, their dependents, and survivors. The 1956 Dependents' Medical Care Act officially established the availability of health care services to active duty dependents, retirees, and their dependents at military treatment facilities (MTFs). It also authorized the Secretary of Defense to contract with civilian health care providers for active duty dependents' medical care.

Since 1956, the peacetime mission of the military health care system has expanded significantly. Changes have affected who is eligible for care under the benefit, what services are covered and how much the benefit costs in terms of costs to the beneficiary and program cost strategies for reimbursing providers. Congress consistently has made some type of change to the military health care benefit during every fiscal year since 1976. Although many of the changes to the benefit have been relatively minor, a number have been significant in terms of affecting the structure of the benefit. The following are the major legislative changes to the benefit that we believe have had the greatest impact on the scope of the benefit and associated costs:

- 1956, authorized the offering of civilian health care coverage to active duty dependents
- 1960, required nonavailability statement for nonemergent inpatient care and set coverage limits on care from civilian providers
- 1966, adopted the Military Medical Benefits Amendments

  - Formally established the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), including coverage for retirees and their dependents
  - Expanded MTF and civilian provider coverage
- 1976, introduced the 40-mile radius catchment area rule and defined excluded services under CHAMPUS
- 1983, authorized CHAMPUS as secondary payer
- 1986, created the Dependents' Dental Program
- 1987, made changes to provider reimbursement methods
  - Implemented CHAMPUS Diagnosis-Related Group (DRGs)
  - Authorized MTF third-party billing for inpatient care
- 1988-89, established catastrophic cap
- 1996, changed to TRICARE.

Unfortunately, we cannot directly identify the cumulative effect of these changes in the benefit on Defense Health Program (DHP) costs over time because the Department of Defense does not have historical, detailed specialty-level cost and workload data for its healthcare program. In addition, we cannot disallow the relative impact of other events occurring over the history of the program, particularly during the Reagan administration in the 1980s. However, our analysis of current cost trends does point to the significant influence of the retiree health benefit on current program costs.

Legislative evolution of the system

The military health care system has two missions. The first is the readiness mission to provide care for U.S. forces who become sick or injured during military engagements. The second is the peacetime mission, which includes maintaining the health of U.S. military personnel and supporting the provision of the military health care benefit to active duty dependents, retirees and their dependents, and survivors. This paper focuses on the legislative and regulatory evolution of this second mission and the costs associated with program change.

The military health care benefit is a congressionally authorized program. The level of the benefit is determined in general terms by the Congress, while the actual implementation is left to the Army, Navy, and Air Force. The responsibility of designing the benefit both empowers and limits the military services. The task of giving structure, shape, and definition to federal policy empowers the services during the implementation process; however, they are limited by readiness requirements, congressional mandates ,and funding.

In recent years, as the military medical departments have implemented the legislatively mandated TRICARE program, the beneficiary population has voiced concerns regarding the perceived deterioration of its health benefit. The military medical departments also have expressed concerns, but of a different nature, relating to Congress's enhancement of the benefit over time without the provision of appropriate funds to support the changes. The Navy believes that it can prepare more informed future budget strategies by carefully examining the evolution of the current military health care benefit and determining the implications of these changes on overall health care costs.

In this paper, we document the legislative and regulatory evolution of the military health care benefit since 1956—the year that Congress

originally authorized the offering of civilian health care coverage to active duty dependents. We also determine the extent to which major changes in the benefit have contributed to changes in program costs. We begin our analysis with an overview of the initial, contemporary, military health care benefit (or baseline benefit) as authorized by Congress. Next, we focus on the specific changes to the benefit that have affected the following features over time: who is eligible for coverage, the range of covered services, the rate of payment for health services, and program administration. Finally, we examine military health care program costs over time to determine the extent to which major program changes have affected costs.

The creation of the military health benefit

The evolution of the contemporary military health care benefit dates to the 1950s, when employer-sponsored health insurance became an accepted component of labor compensation packages in the United States [1]. During this period, Congress enacted the Dependents' Medical Care Act, providing the initial statutory basis for the provision of medical care to active duty members, active duty dependents, and retirees and their dependents [2].

Before 1956, active duty members received first priority for health care at the military, medical treatment facilities (MTFs); their dependents were eligible for care on a space-available basis. The Dependents' Medical Care Act reemphasized the priority care system for active duty members and officially extended eligibility for medical and dental care at the MTF on a space-available basis to active duty dependents, retirees, retiree dependents, and survivors. Under statutory authority, the act defines a dependent as any person who bears any of the following relationships to a member or retired member of a uniformed service, or to a person who died while a member or retired member of a uniformed service [3]:

- Lawful wife
- Unremarried widow
- Lawful, financially dependent husband

- Unremarried widower, financially dependent on the active duty member due to a mental or physical health condition
- Unmarried legitimate child under age 21 (including an adopted child or stepchild)
- Parent or parent-in-law, financially dependent on and residing in the household of the sponsor
- Unmarried legitimate child (including an adopted child or stepchild) who is:
  - (i) over age 21 and financially dependent upon the active duty member due to a mental or physical condition or
  - (ii) under age 23 and enrolled full-time in an institution of higher learning.

MTF-provided services for dependents, retirees, and survivors as defined under the 1956 act included immunizations, acute care, obstetrics, and emergency (medical or dental) treatment. However, a number of health care services were excluded from the baseline benefit, such as mental health care, elective surgical treatment, and dental care (see table 1). Under the law, the military services also had the authority to charge a minimal fee for outpatient care at military clinics "as a restraint on excessive demands for medical care" [4].

Table 1. Excluded MTF services under the Dependents' Medical Care Act, 1956

Inpatient services	Outpatient services
Domiciliary care	Nonemergency ambulance service
Mental health	Home visits
Chronic disease	Dental care
Elective medical care	Prosthetic devices
Elective surgical treatment	Hearing aids
	Eyeglasses
	Orthopedic footwear

Source: [5]

In addition, Congress authorized the Secretary of Defense to establish a health insurance plan for coverage of civilian hospital services for active duty dependents [6]. Health services covered under this plan included hospitalization, medical and surgical services related to hospitalization, physician and surgeon services related to hospitalization, obstetrics, and diagnostic tests and procedures, such as X-ray and lab. For each admission to a civilian hospital, Congress directed the Department of Defense to assess a beneficiary copayment of either $25 per admission or a per diem amount. The beneficiary was responsible for paying whichever was the greater of the two. The Dependents' Medical Care Act specifically excluded coverage of civilian-based outpatient services for active duty dependents, and it did not extend the civilian health care benefit to retirees and their dependents. Consequently, during the late 1950s to mid-1960s, the benefit level for retiree family health was limited to space-available care in military hospitals and clinics.

In general terms, the military health care benefit, as designed in 1956, emphasized a hospital-based system of care. This design was consistent with general labor-based health insurance plans during the period. The proportion of all U.S. workers with hospitalization coverage was 49 percent in 1950 and 74 percent in 1965, while the proportion of all workers with surgical coverage was 36 percent in 1950 and 72 percent in 1965 [7].

In table 2, we compare the baseline benefit by source of care and beneficiary status. Initially, under the 1956 legislation, the benefit level for active duty dependents and retiree families and survivors differed by source of care: military facility versus civilian. For care received within the military facilities, the benefit level was the same. However, only active duty family members received coverage of civilian-provided inpatient health services, and these services included only medical and surgical care related to an inpatient admission. Since 1956, space-available care in the MTF for active duty dependents, retiree families, and survivors has been the mainstay feature of the military health care benefit. In addition, the basic civilian inpatient, cost-share design for active-duty dependents established in 1956 has remained the same throughout the program's history. Active duty dependents pay either $25 for an inpatient admission to a civilian hospital or a per

diem amount—whichever is the greater of the two. The only changes made to this cost-share design have been adjustments to the per diem amount over time.[1]

Table 2. 1956 baseline military health care by source of care and beneficiary status

Source of care	Active duty dependents	Retirees, retiree dependents and survivors
MTF		
Access standard	On space-available basis	On space-available basis
Type of care	Outpatient/inpatient	Outpatient/inpatient
Covered services	Acute medical conditions	Acute medical condition
	Acute surgical conditions	Acute surgical conditions
	Contagious diseases	Contagious diseases
	Immunizations	Immunizations
	Obstetrics	Obstetrics
	Emergencies	Emergencies
Cost-share		
Outpatient service	None	None
Inpatient service[a]	Per diem amount	Per diem amount
Civilian providers		
Access standard	Market demand	n/a
Type of care	Inpatient	none
Covered services	Medical and surgical care incident to a period of hospitalization	n/a
Cost-share[b]	The greater of a $25 fee or per diem amount	

a. In 1966, the per diem amount was $1.75. Information on the rate before 1966 was not available.
b. In then-year dollars.

1. We discuss changes to the active duty, inpatient per diem amounts in more detail in the subsection titled, Beneficiary cost-sharing and program strategies.

The baseline health care benefit depicted in table 2 serves as the initial point of comparison or *baseline benefit* for the remainder of our analysis. The contemporary, military health care benefit has evolved considerably during the past 44 years. Many of the changes result from the numerous technological and medical advancements from which the entire American health care system has benefited. We accept these types of changes as a given part of the military's participation in the American health care delivery system and do not focus on them in our study. Rather, we focus on the definition of the benefit in terms of the following areas:

- The eligible population, that is, the persons eligible for coverage under the military health services system
- Covered services not influenced directly by recent technology advancement
- The rate of payment for health care services, including beneficiary cost-shares and DoD provider reimbursement strategies.

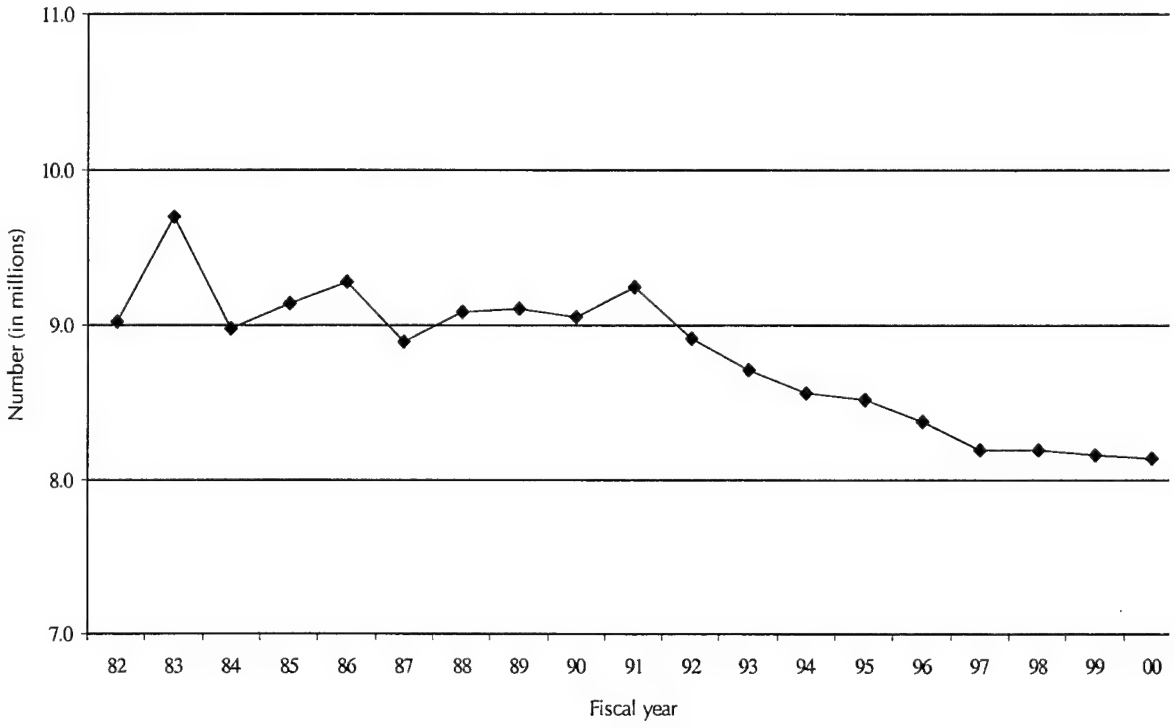
Defining the eligible population

Congress is responsible for defining those persons eligible to receive coverage under the military health care benefit. The basic beneficiary categories—active duty members, active duty dependents, retirees and their dependents, and survivors—have not changed over time. We obtained the available data on the eligible military population spanning the years 1982 to 2000 from the Program and Budget Oversight Office within the Health Budgets and Financial Policy Branch of OSD-(HA). Between 1982 and 1990, estimates of the total eligible military population were fairly steady at slightly over 9.0 million (see figure 1). During the 1990s, the total population slowly decreased to approximately 8.1 million.

As the total number of military beneficiaries eligible for the military health care benefit has decreased, the distribution among the four major beneficiary categories also has changed (see figure 2). During the 1980s, active duty members and their dependents represented over one-half of the eligible beneficiaries. During the 1990s, retirees and their dependents have emerged as the larger segment of the

population. The shift in the distribution can be attributed to several factors. First, the military downsized its numbers of active duty personnel during the 1990s because of the end of the Cold War. Second, the drawdown in active duty members has meant an increase in retirements. Plus, people are living longer and members of the baby-boomer generation are reaching their senior years.

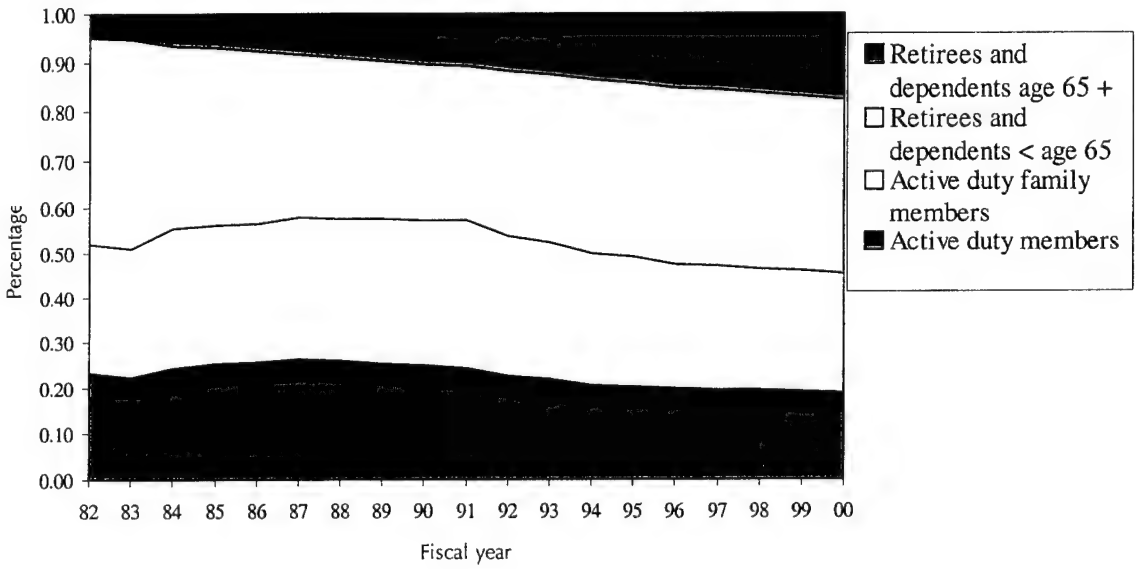
Figure 1. Total eligible military beneficiaries, FY 1982 through 2000



The shift in the distribution of the population is important because it affects health care use and costs. People who are younger tend to be healthier and less expensive in terms of their health care consumption. As people age, their health tends to deteriorate and they become more expensive in terms of the health care requirements. In figure 3, we show the distribution of eligible beneficiaries who have used their military health care benefit for the years 1982 through 1999. From 1982 through 1991, active duty members and their dependents consistently made up about 70 percent of the user

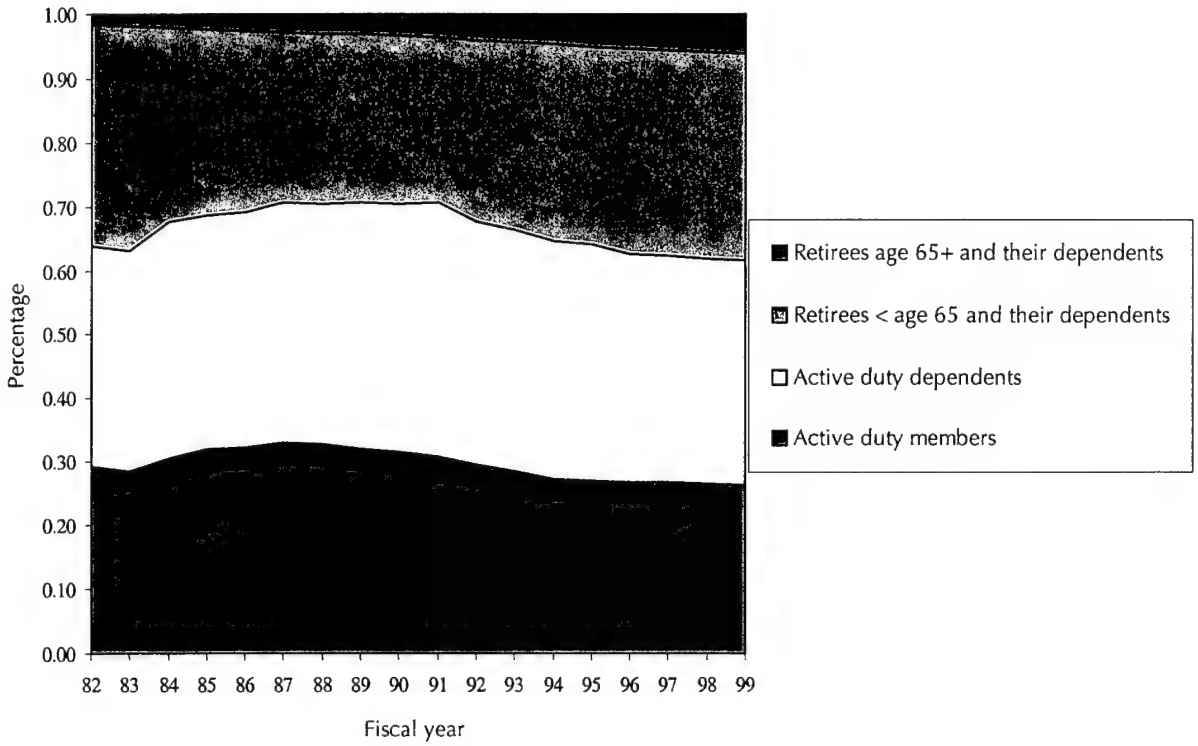
population. This proportion has decreased slowly during the 1990s to about 63 percent. A continued increase in elderly users of the DOD health care benefit may translate to a higher cost per user if their rate of use is higher than that of current users.

Figure 2. Distribution of eligible population by beneficiary type



The definition of who is a *dependent* also has changed. In the first column of table 3, we list those categories of dependents eligible to receive military health care benefits under the 1956 baseline definition. In the second column of table 3, we list the other categories that Congress has added to the definition over time and that, in combination with the baseline categories of dependent, compose the current definition in FY 2000. Specific changes to the definition of *dependent* have focused mostly on spouses, children, and dependents of reserve members.

Figure 3. Distribution of military health care system users by beneficiary status



Traditionally, the wife of an active duty or retired military member always has retained the status of an eligible dependent regardless of health or financial status. The same is not true for husbands of active duty and retired members. Until the 1980s, a husband had to be reliant on his military wife for at least one half of his financial support to qualify as an eligible dependent. Similarly, an unremarried widow remained eligible for coverage under the military health services system while an unremarried widower remained eligible for coverage only if he suffered from some form of physical or mental disability. The Defense Officer Personnel Management Act (DOPMA) of 1980 removed all financial and health status conditions contributing to gender-based limits on military dependency [8]. Former spouses retain eligibility status if they do not remarry. Beginning in fiscal year 1983, the Congress expanded the definition of a military dependent by extending program coverage to the unremarried former spouses of current or former members of the armed forces meeting the following conditions [9]:

- The person was married to the sponsor for at least 20 years, during which time the sponsor was on active duty, and
- The person does not have access to another employer-sponsored health plan.

Table 3. Definition of dependent: baseline definition and expansions

1956 baseline definition	Current definition also includes
Female spouse	Male spouse
Unremarried widow	Unremarried former spouses
Financially dependent husband	
Unremarried widower, financially dependent due to mental/physical capacity	Survivors of reservists who died while on active duty for more than a 30-day period
Children ≤ age 21 (≤ age 23 if in school)	Pre-adoptive dependents (MTF only)
Dependent parent or parent-in-law	Survivors of deceased, retired reservists, 60th birthday rule (MTF only)
Unmarried child age ≥ 21, if financially dependent on sponsor due to mental/physical incapacity	

In FY 1985, the Congress reduced the active duty requirement for unremarried former spouses from 20 to 15 years while maintaining the requirement that the person was married to the sponsor for at least 20 years [10].

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) includes supplemental coverage for active duty spouses and children who are physically or mentally handicapped. Referred to as the Program for the Handicapped, it provides additional health care coverage for services related to the dependent's special condition. The military services concurrently implemented the Program for the Handicapped in 1967 as a supplement to CHAMPUS. Since then, Congress has addressed a number of perceived gaps in the classification of active duty dependents with qualifying special needs. In

1971, eligibility for coverage under the Program for the Handicapped was extended to handicapped children (under the age of 21) surviving active duty members who died while eligible for hostile fire pay [11]. This change was retroactive to 1967 which meant that active duty dependents retroactively eligible for the supplemental coverage could file for reimbursement of covered services rendered between January 1967, and 1971 for which they had paid out of pocket.

Dependency status for legally adopted children dates to the original 1956 legislation, which meant that pre-adoptive children living in the home of an active duty or retired member were not eligible for benefits until the adoption process was legally final. In 1994, Congress extended eligibility for pre-adoptive children placed in the home of an eligible sponsor by an approved adoption agency with the purpose of eventual adoption. However, the pre-adoptive child is eligible for care only in the MTF and is not eligible for coverage under CHAMPUS benefits [12].

In recent years, Congress has passed several changes to Title X addressing the eligibility status of dependents and surviving dependents of reservists and retired reservists. These changes recognize the role and contribution of the reserve component of the U.S. Armed Forces by enhancing the health care benefit component of their compensation packages with respect to the eligibility status of their dependents. In 1994, survivors of members (reservists) who died while on active duty for a period of more than 30 days became eligible for care in the MTFs for a period of one year, from the date of their sponsor's death [12]. Under the 1996 Defense Authorization Act, Congress expanded coverage for surviving dependents of retired reservists eligible at the time of their death for retired pay, provided they had reached 60 years of age. Under the act, surviving dependents are eligible to receive medical care from MTFs on a space-available basis after the date on which their deceased sponsor would have turned 60 [13]. In 1998, unremarried surviving retiree spouses and the surviving dependents of reservists who died while on active duty for a period of greater then 30 days became eligible for coverage under the military dental insurance plan [14]. Finally, in FY 1999, dependents of retirees became eligible for coverage under the Retirees' Dental Insurance

plan in cases where the retiree has coverage under some other dental insurance plan that does not extend coverage to dependents [15].

We show the estimated number of all military beneficiaries by eligibility status for fiscal year 2000 in table 4. Nearly 55 percent of military beneficiaries derive their eligibility from retiree status or as dependents of retirees. Active duty members and their dependents make up about 44 percent of all military beneficiaries. The overall effect of adjustments to the definition of *dependency* on the current number of eligibles is small among active duty, retiree, and survivor family members. Less than 1 percent of all beneficiaries were male spouses of active duty members. Only 1 percent of beneficiaries were single adult dependents between the ages of 18 and 64, and only one-tenth of a percent of beneficiaries appear to be male spouses of retirees or dependent parents (senior dependents, age 65+) of active duty members.

Table 4. Distribution of all military beneficiaries

Eligibility status	Total number	Percent
Active duty members (including guard and reserves)	1,524,318	18.5
ADFM female spouses, age < 65	727,876	8.8
ADFM male spouses, age < 65	49,794	0.6
ADFM dependents, age 0-17	1,298,515	15.7
ADFM single adult dependents, age 18-64	81,525	1.0
ADFM senior dependents, age 65+	4,793	0.1
Retirees, age < 65	1,150,492	13.9
Retirees, age 65+	812,402	9.8
Retiree and survivor female spouses, age 18-64	985,169	11.9
Retiree and survivor male spouses, age 18-64	10,263	0.1
Retiree and survivor female spouses, age 65+	403,264	4.9
Retiree and survivor male spouses, age 65+	679	0.0
Retiree and survivor dependents, age 0-17	534,747	6.5
Retiree and survivor single adult dependents, age 18-64	361,219	4.4
Retiree and survivor single senior dependents, age 65+	257,153	3.1
Others, age 0-17	5,978	0.1
Others, age 18-64	33,980	0.4
Others, age 65+	9,045	0.1
Total	8,251,212	100.0

Source: Managed Care Forecasting and Analysis System, OSD(HA)

Changes to covered medical services

Under the baseline benefit, beneficiary[2] access to care in the MTF was limited to a space-available basis for four general types of services: acute care, immunizations, obstetrics, and emergency treatment. In addition, the military health care benefit extended coverage for inpatient care to active duty dependents. In this section, we focus on changes to covered medical services that have occurred in the military health care benefit since 1956.

In identifying changes to covered medical services, we do not include changes that result from advancements in technology and medical science, new treatments, new training curricula, and other innovations furthering the medical professions and the provision/pursuit of health care. In general, Congress does not legislate on coverage issues that are related to the implementation of medical innovations in military medical treatment facilities or in the general market. The respective medical departments of the military services address these issues as required in the everyday administration of their health care facilities, as do civilian providers. Congress *does* legislate changes to covered services when extending coverage to a service once excluded or discontinuing coverage of a service once included in the benefit. These changes tend to affect CHAMPUS more than the MTFs.

In table 5, we list the covered services under the baseline benefit and services added over time. Only minor changes, initiated by the Department of Defense, occurred in the military health care benefit during the early 1960s.[3] The first major change to the benefit occurred under the Military Medical Benefits Amendments of 1966

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2. By *beneficiary*, we refer to active duty dependents, retirees, retiree dependents, survivors, and their dependents.

3. During this time, state and federal policy-makers focused their attention on extending coverage to select segments of the population with no source of health insurance: the elderly, the working poor, and the unemployed. In 1965, the federal government established the Medicare and Medicaid programs to provide coverage to these groups. Medicare serves as the federally implemented health insurance program for those aged 65 and over, and Medicaid is the state implemented health insurance program for low-income individuals.

Table 5. Military health care benefit, covered services by source of care (year service added to benefit in parentheses)

Baseline benefit	Added covered services
MTF	
Inpatient care	Dental (1960)
Outpatient care	Pharmacy (1966)
Acute care, medical	Mental health (1966)
Acute care, surgical	Diagnostic tests/services (1966)
Contagious diseases	Ambulance services (1966)
Immunizations	Durable medical equipment (1966)
Obstetrics	Physical exams (1966)
Emergencies	Immunizations (1966)
	Eye exams (1966)
	National Cancer Institute phase II/III clinical trials (1996)
	National Cancer Institute prevention trials (1999)
Civilian providers	
Inpatient care (only for active-duty dependents)	Emergency care (1960)
	Nonemergency surgical (1960)
	Inpatient care, all beneficiary categories (1966)
	Outpatient hospital-based services (1966)
	Physician services, acute care (1966)
	Contagious diseases (1966)
	Obstetrics (1966)
	Mental health (1966)
	Diagnostic tests/services (1966)
	Ambulance services (1966)
	Durable medical equipment
	Medically necessary dental care (1966)
	Physical exams, only for active duty dependents living overseas (1966)
	Immunizations only for active duty dependents living overseas (1966)
	Pharmacy (1966)
	Family planning (1970)
	Elective reconstructive surgery (1982)
	Wigs (1983)
	Liver transplant (1984)
	Eye exams (1985)
	Dependents' dental (1986)
	SIDS monitors (1988/89)
	Mammograms and Paps (1991)
	Expanded family counseling (1991)
	Hospice care (1992)
	Expanded dental for crowns, orthodontics, gold fillings, and dentures (1993)
	Mail-order pharmacy (1996)
	Routine physicals, preventive care (1996)
	Immunizations, preventive care (1996)

when Congress enacted a number of provisions expanding both MTF- and civilian-provided health services [16]. The covered services added under the Act essentially provided comprehensive health service coverage for military beneficiaries. For care received within a military facility, the expanded covered services included pharmacy, mental health care, diagnostic services, physical exams, eye exams, and immunizations. Dental care was authorized only when necessary as part of medical or surgical treatment. Routine dental care at the MTF was available only for families stationed overseas and in areas of the United States without adequate civilian facilities. Congress did not make any major changes to MTF-covered services for the next 30 years. It extended eligibility for participation in National Cancer Institute (NCI) experimental clinical trials to military beneficiaries in 1996 and cancer prevention trials in 1999 as part of an interagency partnership between DOD and NCI [17]. Both types of care typically are not covered under civilian health plans.

The creation of CHAMPUS

The 1966 legislation also broadened the authority of the military services to contract with civilian providers to supplement MTF health care through a program commonly known as CHAMPUS. Modeled after the Blue Cross/Blue Shield, high-option plan provided under the Federal Employees' Health Benefits Program (FEHBP), CHAMPUS expanded the military health care benefit both in terms of eligibility and covered services [18].[4] First, retirees not eligible for Medicare Part A benefits and their dependents became eligible for CHAMPUS coverage. Second, the program provided coverage for civilian-based health care. The range of covered services was nearly the same as that available at the MTF. Services not covered under

4. Congress created the Federal Employees' Health Benefits Program under Public Law 86-382, enacted 28 September 1959. The act became effective on the first day of the first pay period on or after 1 July 1960. The Office of Personnel Management (previously known as the Civil Service Commission) writes the needed regulations to implement the act and oversee the program. These regulations are in Chapter 89 of Title 5 of the *United States Code* and Chapter 16 of Title 48, *Code of Federal Regulations.*

CHAMPUS included routine dental care, physical exams, immunizations, routine newborn care, well baby visits, and eye exams.

Since 1966, Congress has changed the definition of covered services under the CHAMPUS program a number of times. These changes have tended to expand rather than limit the level of services covered. One example of a congressional change that limited covered services is found under the National Defense Authorization Act, 1976, in which the following services are excluded from CHAMPUS coverage [19]:

- Marital, child, pastoral and family counselors without a non-availability statement
- Special education, except when it was necessary to provide it as an inpatient service
- Counseling or therapy for sexual dysfunction
- Treatment for obesity
- Reconstructive surgery for psychological rather then medical purposes.

Congress reinstated CHAMPUS coverage of nonphysician counseling services during FY 1977. However, qualifying for coverage requires a physician's referral for counseling services [20], and the referring physician must monitor the care through the receipt of counseling treatment progress reports. Congress repealed the 1976 restrictions on the availability of certified marital and family counseling under CHAMPUS in FY 1991 [21], but it did place certain limits on the mental health benefits available to eligible beneficiaries in an attempt to control costs. Among the limitations was a maximum of 30 days of inpatient treatment for those 19 and older, 45 days for 18 and under, and a maximum of 150 days of inpatient mental health care provided as residential treatment. These limits did not apply to beneficiaries with mental or physical handicaps or receiving care under the Program for the Handicapped [21]. For nonemergency situations, inpatient mental health care required pre-admission authorization; in emergency situations, the admission requires approval for the continuation of such services within the first 72 hours.

Dental insurance

In terms of major changes, the legislative addition of a dental insurance plan for active duty dependents in FY 1986 represents the second change of import for the military health care benefit [22]. The Dependents' Dental Program gives active duty members residing within the continental U.S. the option to purchase insurance for their dependents that covers basic diagnostic, preventive, and restorative services provided in the civilian sector. Congress provided for the offering of dental insurance programs for purchase by members of the Selected Reserve and retirees during the mid- to late-1990s [23, 24].

Under the Dependents' Dental Program, the Department of Defense and the military sponsor share the cost of the monthly premium. There are no beneficiary copayments for routine dental care, but the costs for certain services (e.g., basic restoration, crowns, and dental appliance repairs) are shared. The beneficiary cost-share for these services is 20 percent; the government pays the remainder. The Department of Defense first offered beneficiaries the option of purchasing coverage under the Dependents' Dental Program on 1 August 1987 [25]. Congress enhanced the benefits available through the Dependents Dental Plan in 1993, adding coverage for sealants, endontics (root canal treatment), periodontics, extractions, prosthodontics (bridges and dentures), orthodontics, crowns, and casts [25].[5] The monthly premium was set at $10 for coverage of one dependent and $20 for coverage of two or more dependents. Beneficiary cost-share payment levels for newly covered services range from 20 to 50 percent.

Since 1995, Congress has added dental insurance programs for members of the Selected Reserve of the Ready Reserve and retirees. Congress authorized the creation of the TRICARE Selected Reserve Dental Program (TSRDP) during FY 1996 [23] and directed the Department of Defense to establish a dental insurance plan for military retirees the following fiscal year [24]. Both plans are premium-based, indemnity insurance programs that cover expenses associated with basic dental care, including diagnostic services, preventive

5. Expanded coverage under the Active Duty Dependents' Dental Plan became effective on 1 April 1993.

services, basic restorative services, and emergency oral exams. The TRICARE Selected Reserve Dental Program covers only the dental care expenses of members of the Selected Reserve of the Ready Reserve; it does not cover family members. The enrollee and the Department of Defense share the premium payments, but the beneficiary's premium share may not exceed $25 per month. Enrollment of eligible beneficiaries in the program began on 22 January 1998 [26]. The Retirees' Dental Insurance Plan covers dental care expenses of retirees and members of the retired reserve under age 60, their dependents, and survivors. The beneficiaries bear the entire cost of the premium. Enrollment in the Retiree Dental Plan began on 1 April 1998 [27].[6]

Preventive health care services

During the 1990s, the Department of Defense made the transition from its traditional military health care benefit supplemented by CHAMPUS to an integrated system of managed care, known as TRICARE. Before 1991, CHAMPUS did not provide coverage of preventive health care services. As part of the basic TRICARE program design, Congress made several changes to the benefit culminating in full-range coverage of preventive health services.

The first in this series of changes involves coverage of preventive health care services for women. Traditionally, CHAMPUS had covered the cost of diagnostic Pap smears and mammograms only in the specific case of treating an illness. During FY 1991, Congress expanded the preventive health care benefits available to women to include coverage of the diagnostic and preventive use of Pap tests and mammograms [21]. During FY 1994, Congress further enhanced the medical benefits available to women in the military health care system by providing completely for both primary and preventive health care [28]. Covered services included counseling, Pap smears, breast examinations, mammography, comprehensive obstetrical and gynecological care, pregnancy and pregnancy prevention, infertility, sexually

6. Under the National Defense Authorization Act, 1998, Congress delayed implementation of the Retirees Dental Insurance Plan from 1 October 1997 to 1 April 1998.

transmitted diseases, menopause, hormone replacement, physical and psychological conditions resulting from acts of sexual violence, and gynecological cancers.

Congress further enhanced the coverage of preventive services in legislation for FY 1996, when it removed all restrictions previously in existence on the availability of well care, immunizations, and routine physical exams [23]. Finally, during FY 1997, Congress extended coverage to eligible male beneficiaries for preventive health care screenings for colon and prostate cancer [24].

Expansion of the pharmacy benefit

The military health care benefit has included coverage of prescription pharmacy drugs since 1966. The pharmacy benefit extends to all drugs approved by the Food and Drug Administration. Traditionally, beneficiaries have had two pharmacy options. Under the first option, a beneficiary could have prescriptions filled by the MTF pharmacy at no charge, regardless of whether the prescription was written by a military or a civilian provider. Alternatively, a beneficiary could have prescriptions filled at a civilian pharmacy, in which case the beneficiary would pay some of the prescription cost.

Congress made two major changes to the pharmacy benefit during the 1990s. The first change directs the Department of Defense to design and implement a nationwide TRICARE retail pharmacy network program and mail-service pharmacy program. The second change addresses the loss of access to free pharmaceuticals for Medicare-eligible beneficiaries living in areas affected by military base realignment and closure (BRAC). We refer to this second change as the Medicare-eligible, BRAC pharmacy benefit.

Under the TRICARE program, civilian pharmacies supplement the direct-care-system pharmacy benefit under a retail pharmacy option and a mail-order program. In the National Defense Authorization Act of 1993, Congress directed that Medicare-eligible beneficiaries were eligible for these pharmacy programs if they lived in a catchment area adversely affected by the closure of the local MTF [29]. Under the National Defense Authorization Act of 1995, Congress further

expanded this eligibility to include Medicare-eligible beneficiaries who could demonstrate a previous reliance on the pharmacy services of the local MTF [12]. To qualify for pharmacy coverage, the Medicare-eligible beneficiary had to have used the MTF pharmacy within the last 12 months of its operation. The BRAC pharmacy contracts expired in 1998 and the clients of this program were shifted to the National Mail Order Pharmacy (NMOP) contract. In April 1998, the existing mail-order prescription benefits were transferred out of the support contracts for TRICARE, and the NMOP became available to all TRICARE-eligible beneficiaries in 1998 [30]. We summarize current beneficiary pharmacy benefits below, in table 6.

Table 6. Current beneficiary pharmacy benefit coverage

MTF pharmacy	Retail pharmacy network and mail-order pharmacy
Active duty members	Active duty members
Retirees under age 65	Retirees under age 65
Dependents and survivors	Dependents and survivors under age 65
Medicare-eligible	Medicare-BRAC eligibles Medicare-PRIME enrollees

Hospice care

To address the demands for care of the terminally ill in nonhospital settings, Congress authorized coverage of civilian hospice care, under the 1992-93 Defense Authorization Act, establishing a benefit similar to the one provided by Medicare [31]. The benefit provides eligible terminally ill beneficiaries with an alternative to hospital-based, curative treatments that may no longer be appropriate for or desired by the patient. Hospice care is palliative care, emphasizing supportive home care and pain control. Coverage is available to individuals with a prognosis of less than 6 months to live. Covered services include physicians, nursing care, medical social services, counseling for the patient and family members caring for the patient at home, home

health aide services, medical equipment, supplies, drugs, physical therapy, occupational therapy, and speech therapy.

There are four distinct periods of care under hospice: an initial period of 90 days, a second period of 90 days, a subsequent period of 30 days, and a final period of unlimited duration. CHAMPUS uses the hospice rates established by the Medicare program for these services. The beneficiary pays no deductibles under the CHAMPUS hospice benefit. CHAMPUS covers the full cost of hospice care except for 5 percent of the cost of outpatient drugs or a $5 copay per prescription (whichever is less) and a 5-percent copay of the CHAMPUS-determined amount for each day of inpatient respite care. The yearly beneficiary cost-share for respite care during a hospice period is capped at the Medicare inpatient deductible for the given year. Hospice coverage for military beneficiaries became effective on 1 February 1995 [32].

Over time the military health care benefit experienced three major changes in the level of covered services. First, the benefit experienced the largest level of increase in covered services in 1966 when Congress directed DOD to create CHAMPUS. The creation of CHAMPUS significantly expanded the level of civilian-based outpatient and inpatient care for active duty dependents, retirees and their dependents, and survivors. The next major change occurred in 1986 with the addition of the Dependents Dental Program for active duty dependents. Finally, during the 1990s, as part of a larger transition to a system of managed care and a focus on population health, Congress has extended coverage to a full-range of preventive health care services.

Beneficiary cost-sharing and program cost strategies

How much does military health care cost in terms of dollars, and how has this changed over time? There are several perspectives from which to answer this question: (1) from the point of view of the beneficiary, (2) in terms of provider reimbursement strategies, and (3) in terms of total program costs to the military services. In this section, we consider this question from the first two perspectives. First, we take a look at how much military beneficiaries pay directly for their health care and how their cost-sharing responsibilities have changed since

the 1950s. Second, we examine various financial strategies that the Department of Defense has used to control overall program costs. Then, in the next section, we examine the relative impact of major changes to the benefit on overall military health care program costs.

Beneficiary cost-sharing

In the U.S. health care market, several types of expenses contribute to a person's direct (out-of-pocket) health care costs. These expenses may include a monthly insurance premium, an enrollment fee, a yearly deductible, and copayments for health care services. Military beneficiaries' out-of-pocket health care costs vary depending on whether they receive their care in a military health care facility or in the civilian sector from a civilian provider. Under the traditional military health care benefit, beneficiaries did not pay a monthly premium—as is more often the case in the civilian, employer-based, health insurance market—for medical coverage regardless of whether they received their care in a military facility or from a civilian provider. However, they do pay a monthly premium, as noted in the previous section, for coverage under one of the dental insurance programs. Under the current managed care program, TRICARE, retirees enrolling in the HMO option pay an enrollment fee of $230 for an individual and $460 for a family.

Care received within a military facility has always been rendered at no charge for outpatient care and at a minimal per diem rate for inpatient care. In table 7, we list the per diem rate for inpatient care at the MTF by fiscal year from 1952 through 2000. The per diem cost-shares for inpatient care at military facilities was $1.75 (in then-year dollars) from 1956 through 1973 [33, 34]. The Department of Defense assessed the first increase in the per diem amount in 1974, doubling the per diem amount from $1.75 to $3.50, and has made slight adjustments to the amount each fiscal year since that time. The current per diem amount in FY 2000 is $10.85 [35]. Represented in 1999 dollars, the yearly per diem inpatient cost-shares range over time from about $7 to $13. The inpatient per diem, expressed in 1999 dollars, decreased slowly from $10.58 to $6.77; increased to $12.76 in 1974, and dropped to between $10 and $11 during the 1980s and 1990s. In general, over time, the inpatient per diem has been about $10.

Table 7. Beneficiary per diem cost-shares for inpatient care at military medical facilities

Fiscal year	Per diem charge	
	Then-year dollars	1999 dollars
1956	1.75	10.58
1957	1.75	10.43
1958	1.75	10.07
1959	1.75	9.80
1960	1.75	9.72
1961	1.75	9.57
1962	1.75	9.48
1963	1.75	9.37
1964	1.75	9.26
1965	1.75	9.14
1966	1.75	8.99
1967	1.75	8.74
1968	1.75	8.49
1969	1.75	8.15
1970	1.75	7.73
1971	1.75	7.30
1972	1.75	7.00
1973	1.75	6.77
1974	3.50	12.76
1975	3.75	12.32
1976	3.90	11.74
1977	4.10	11.67
1978	4.40	11.75
1979	4.65	11.55
1980	5.00	11.13
1981	5.50	10.79
1982	6.30	11.21
1983	6.55	10.97
1984	6.80	11.04
1985	7.10	11.05
1986	7.30	10.96
1987	7.55	11.13
1988	7.85	11.17
1989	8.05	11.00
1990	8.35	10.89
1991	8.55	10.58
1992	8.95	10.63
1993	9.30	10.72
1994	9.30	10.41
1995	9.50	10.36
1996	9.70	10.32
1997	9.90	10.23
1998	10.20	10.36
1999	10.45	10.45
2000	10.85	10.56

Source: Published yearly in the *Federal Register* through 1997; thereafter published on the TRICARE Management Agency web-site.

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) has represented the DOD beneficiary "insurance program" for coverage of care received in the civilian sector for most of the period between 1956 and 2000. Congress authorized the creation of CHAMPUS in 1966 and the Department of Defense initiated coverage under the program on 13 February 1967 [33]. CHAMPUS covers the cost of civilian care for active duty dependents, retirees, retiree dependents, and survivors. When beneficiaries use CHAMPUS, they incur out-of-pocket costs in terms of deductibles and copayments; they do not pay a monthly premium for coverage.

In table 8, we outline the basic cost-sharing structure for selected years from 1967 through 2000 for beneficiaries using CHAMPUS (referred to as the TRICARE standard option in 2000). From 1967 through 1990, beneficiaries were required to satisfy an annual deductible of $50 for an individual and $100 for a family. During FY 1991, the annual deductible amount increased to $150 for an individual and $300 for a family. The increase in deductible amount applied to all eligible beneficiaries except enlisted members and their families whose pay grades are below E-5 [21]. After the deductible is met, copayment levels for outpatient care are 20 percent of the allowable CHAMPUS amount for active duty dependents and 25 percent for retirees and their dependents.

For inpatient care, active duty dependents pay the greater of $25 per admission or a per diem rate equivalent to the MTF inpatient per diem (reported in table 7). The inpatient cost share for retirees was set at 25 percent of the CHAMPUS allowable amount for participating providers. Beneficiaries receiving services from providers who did not participate in CHAMPUS (meaning they agreed to accept the allowed amount as payment in full) could be held responsible for paying billed amounts in excess of the allowed amount. CHAMPUS reimbursement schemes traditionally have followed those used under the Medicare program. Consequently, CHAMPUS reimbursement was on a fee-for-service basis for the first 10 years of the program and then changed to a usual, customary, and reasonable (UCR) reimbursement system in 1977. During FY 1988, DOD began using a prospective payment system (PPS), modeled after the Medicare system, to reimburse inpatient hospital expenses under CHAMPUS

Table 8. Cost-sharing for care in the civilian sector by beneficiary status, 1967-2000

	Fiscal year				
	1967	1977	1988	1994	2000[a]
Active duty dependents, E-4 and below					
Annual deductible					
Individual	$50	$50	$50	$50	$50
Family	$100	$100	$100	$100	$100
Outpatient copay	20%	20%	20%	20%	20%
Inpatient copay: the greater of $25/ admission or the per diem amount	$1.75	$4.10	$7.55	$9.30	$10.85
Annual catastrophic cap	----	----	$1,000	$1,000	$1,000
Active duty dependents, E-5 and above					
Annual deductible					
Individual	$50	$50	$50	$150	$150
Family	$100	$100	$100	$300	$300
Outpatient copay	20%	20%	20%	20%	20%
Inpatient copay: the greater of $25/ admission or the per diem amount	$1.75	$4.10	$7.55	$9.30	$10.85
Annual catastrophic cap	----	----	$1,000	$1,000	$1,000
Retirees and their dependents					
Annual deductible					
Individual	$50	$50	$50	$150	$150
Family	$100	$100	$100	$300	$300
Outpatient copay	25%	25%	25%	25%	25%
Inpatient copay	25%	25%	Lesser of 25% of DRG[b] amt. or per diem of $235	Lesser of 25% of DRG[b] amt. or per diem of $323	Lesser of 25% of DRG[b] amt. or per diem of $390
Annual catastrophic cap	----	----	$10,000	$7,500	$7,500

a. TRICARE standard option.
b. DRG stands for diagnosis-related group.

[36].[7] At this time, the inpatient cost-sharing scheme for retirees and their dependents also changed: retirees now pay the lesser of 25 percent of the prospectively determined amount or a per diem charge. In 1988, the per diem charge was $235; in 2000, it is $390.

Also since FY 1988, the amount a military beneficiary is required to pay annually for care under CHAMPUS has been limited under a congressionally set catastrophic cap [37]. Congress originally set the cap at $1,000 for active duty members and their dependents and $10,000 for all other eligible beneficiaries. Congress passed the military beneficiary catastrophic cap during the same session in which it passed the Medicare catastrophic cap. While Congress repealed the cap for Medicare beneficiaries, the provision remained in place for military members. In 1993, Congress reduced the catastrophic cap for retirees and their dependents to $7,500 per year [29].

In real terms, what has happened to beneficiary cost shares for health care in the civilian sector under CHAMPUS? We express the cost-sharing information in 1999 dollars in table 9. We find that in real terms, beneficiary deductible amounts have decreased significantly since 1967. Inpatient per diem amounts have remained about the same for active duty dependents and increased somewhat for retirees and their dependents. The annual catastrophic cap also has decreased by about one-third for active duty dependents and by nearly 50 percent for retirees and their dependents.

Military health services system cost containment strategies

A common theme occurring throughout the 46 years of legislation addressing the military health care benefit is Congressional requests of the Department of Defense to develop and implement strategies to contain overall military health care program costs. These *requests* vary in tone from that of encouragement to directives. Congressional oversight and demands on the military health care program have increased and become stronger in tone particularly during the past 10 to 15 years as overall U.S. health care expenses have increased and as the military has downsized since the end of the Cold War. In this

7. We will discuss the prospective payment system in more detail in the following section on strategies used by DOD to contain health care program costs.

Table 9. Cost-sharing for care in the civilian sector by beneficiary status, 1967-1999, in 1999 dollars

	Fiscal year				
	1967	1977	1988	1994	1999[a]
Active duty dependents, E-4 and below					
Annual deductible					
Individual	$250	$142	$71	$56	$50
Family	$499	$285	$142	$112	$100
Outpatient copay	20%	20%	20%	20%	20%
Inpatient copay: the greater of $25/ admission or the per diem amount	$8.74	$11.67	$10.74	$10.41	$10.45
Annual catastrophic cap	- - - -	- - - -	$1,423	$1,119	$1,000
Active duty dependents, E-5 and above					
Annual deductible					
Individual	$250	$142	$71	$168	$150
Family	$499	$285	$142	$336	$300
Outpatient copay	20%	20%	20%	20%	20%
Inpatient copay: the greater of $25/ admission or the per diem amount	$8.74	$11.67	$10.74	$10.41	$10.45
Annual catastrophic cap	- - - -	- - - -	$1,423	$1,119	$1,000
Retirees and their dependents					
Annual deductible					
Individual	$250	$142	$71	$168	$150
Family	$499	$285	$142	$336	$300
Outpatient copay	25%	25%	25%	25%	25%
Inpatient copay	25%	25%	Lesser of 25% of DRG[b] amt. or per diem of $334	Lesser of 25% of DRG amt. or per diem of $362	Lesser of 25% of DRG amt. or per diem of $390
Annual catastrophic cap	- - - -	- - - -	$14,227	$8,394	$7,500

a. TRICARE standard option.
b. DRG stands for diagnosis-related group.

section, we describe the various cost containment strategies implemented by DOD during the past 45 years. We identify two patterns in DOD's cost containment behavior. First, DOD tends to follow both Medicare and civilian market strategies. Second, though not the presumed intent of the adopted strategies, these changes may contribute to complications in the billing and claims resolution process for beneficiaries.

Following Medicare and the U.S. health care market

The military health care program has tended to follow cost containment strategies adopted by the Medicare Program and generally occurring in the U.S. health care market. Specifically, the military health care program has reimbursed civilian providers under the same rules used by Medicare. For the first 10 years of the program, CHAMPUS reimbursed providers on a fee-for-service basis, paying billed charges. This practice was consistent with the indemnity-based, fee-for-service method used by the health insurance industry in the 1970s. In 1978, Congress directed DOD to use a usual, customary, and reasonable (UCR) reimbursement strategy that limited civilian provider reimbursement for medical charges to not more than the 75th percentile of customary charges for similar services in the same general geographic location [38].[8] One year later, however, Congress increased the CHAMPUS UCR reimbursement limit to the 80th percentile [39].

In 1984, Congress gave CHAMPUS the statutory authority to reimburse institutional providers for inpatient care based on a diagnosis-related-group (DRG) system [40]. The DRG is a patient classification scheme consisting of clinically coherent classes of patients who are similar in their consumption of hospital resources. Under the Prospective Payment System (PPS), CHAMPUS reimburses hospitals for inpatient health care at a fixed, predetermined rate per discharge according to their assigned DRG. The underlying economic assumption is that DRGs provide hospitals with the incentive to control their costs or risk running a deficit [41]. The DRG-based payment system, which was first implemented by Medicare under the PPS in 1984,

8. Congress had directed this change in the Medicare program in 1973.

reimburses hospitals for inpatient health care at a fixed, predetermined rate per discharge. CHAMPUS began using the DRG system to pay for inpatient hospital expenses on 1 October 1987 [36]. The MTFs began use of the DRG system for third-party billing purposes beginning FY 1995 [42].

The DRG payment amount represents the CHAMPUS-determined allowable amount for inpatient hospital services when the CHAMPUS and beneficiary contributions are combined. As noted in the previous section, the amount CHAMPUS contributes to the total DRG payment varies by the status of the military beneficiary (see table 8). Most hospitals accept assignment of the CHAMPUS DRG-determined amount and do not demand payment above that figure. In fact, Congress has linked Medicare and CHAMPUS by statute with respect to reimbursement schemes: all hospitals that participate in Medicare must also participate in CHAMPUS for inpatient services [43, 44].

The next change that we consider represents a major change to the military health care benefit, in terms of the basic organization and structure of the benefit. For most of the history of the contemporary military health care benefit, DOD has provided the benefit to its eligible beneficiaries through a loosely coordinated system of military hospitals and clinics and the CHAMPUS insurance program. Beneficiaries moved freely between the direct care system and CHAMPUS. There was limited coordination of benefits between the military and civilian components of the system and among the three services. The system in many ways reflected the loose organization of health care more generally in the United States during the 1960s through the early to mid-1980s.

As health care costs have increased in the United States during the 1980s and 1990s, the system has evolved to a more integrated and managed approached to care. Because the military health care system has tended to follow changes in Medicare and the U.S. health care system in general, it is not surprising that during the early to mid-1990s Congress mandated DOD to develop and implement "a nationwide managed health care program for the military health services system" [45]. TRICARE represents the Defense Department's new managed health care system implemented nationwide between 1995

and 1998. In accordance with Congress's direction, DOD modeled the TRICARE program on HMO plans offered in the private sector and other similar government health insurance programs. The program offers three choices to CHAMPUS-eligible beneficiaries:

- Enroll in an HMO-like option called TRICARE Prime.[9]
- Use a network of civilian preferred providers on a case-by-case basis under TRICARE Extra.
- Receive care from nonnetwork providers under TRICARE standard (essentially the same as standard CHAMPUS).

We provide a comparison of the cost-sharing features for each of the TRICARE options in table 10.

All active duty military personnel are enrolled automatically in Prime at their nearest military medical facility. Prime enrollment also is available to all other persons eligible for military health care, except those who are eligible for Medicare. Eligible beneficiaries may enroll in Prime at any time during the year; there is no defined "open season" for enrollment. Each enrollee chooses or is assigned a primary care manager (PCM) at either the nearest military clinic or civilian physician who is a contracted member of the TRICARE Prime network. A network of military and civilian specialists to whom patients are referred for specialty care supports the PCM.

Beneficiaries who enroll in TRICARE Prime have reduced out-of-pocket costs and are guaranteed access to care according to a set of defined strict standards. Prime includes coverage of a variety of preventive and wellness services at no cost to the enrollee whether performed at a military or civilian network facility. Examples include eye exams, hearing tests, immunizations, mammography, Pap smears, prostate exams, and other cancer-prevention and early diagnosis services. Non-active-duty Prime enrollees may seek care from nonnetwork providers through a point-of-service option, but they must pay a higher share of the cost.

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9. Under TRICARE, DOD also offers eligible beneficiaries in seven areas of the country the option of enrolling in the Uniformed Services Family Health Plan (USFHP), a comprehensive managed care plan implemented by DOD in the Uniformed Treatment Facilities, which were formerly a part of the Public Health Service. For more information about the USFHP, see the appendix.

Table 10. TRICARE cost-sharing features

Feature	TRICARE Prime	TRICARE Extra	TRICARE Standard
Choice of civilian doctors, hospitals, clinics	Must choose from government-approved network	Can choose from government-approved network for lower cost	Unlimited
Annual enrollment fees			
All active duty[a]	None	None	None
Retirees	Individual: $230 Family: $460	None	None
Annual outpatient deductibles			
E-4 and below[a]	None	Individual: $50 Family: $100	Individual: $50 Family: $100
All other active duty[a]	None	Individual: $150 Family: $300	Individual: $150 Family: $300
Retirees	None	Individual: $150 Family: $300	Individual: $150 Family: $300
Catastrophic cap			
All active duty[a]	$1,000	$1,000	$1,000
Retirees	$3,000	$7,500	$7,500
Copayments for visit to civilian doctor			
E-4 and below[a]	$6	15 percent[c]	20 percent[b]
All other active duty[a]	$12	15 percent[c]	20 percent[b]
Retirees	$12	20 percent[c]	25 percent[b]
Prescription drugs (retail network)			
All active duty[a]	$5	15 percent[c]	20 percent[b]
Retirees	$9	20 percent[c]	25 percent[b]
Mail order pharmacy			
All active duty[a]	$4 for up to a 90-day supply	$4 for up to a 90-day supply	Unavailable
Retirees	$8 for up to a 90-day supply	$8 for up to a 90-day supply	Unavailable

Table 10. TRICARE cost-sharing features (continued)

Feature	TRICARE Prime	TRICARE Extra	TRICARE Standard
Copayments at civilian hospitals for inpatient care			
All active duty[a]	$11 per day ($25 minimum per stay); $20 per day for mental health	$10.45 per day ($25 minimum per stay); 20 percent for mental health	$10.45 per day ($25 minimum per stay); 20 percent for mental health
Retirees	$11 per day ($25 minimum per stay); $40 per day for mental health	Lesser of $250 per day or 25 percent of hospital charges, plus 20 percent of professional fees; for mental health, 20 percent of all charges[c]	Lesser of $376 per day or 25 percent of hospital charges, plus 25 percent of professional fees; for mental health, lesser of $140 per day or 25 percent of all charges[b]
Ambulance service			
E-4 and below[a]	$10	20 percent[c]	20 percent[b]
All other active duty[a]	$15	20 percent[c]	20 percent[b]
Retirees	$20	25 percent[c]	25 percent[b]
Outpatient surgery			
All active duty[a]	$25	$25	$25
Retirees	$25	20 percent[c]	25 percent[b]
Preventive services	$0	Not covered	Not covered
Medical equipment patient takes home			
E-4 and below[a]	10 percent[b]	20 percent[c]	20 percent[b]
All other active duty[a]	15 percent[b]	20 percent[c]	20 percent[b]
Retirees	20 percent[b]	25 percent[c]	25 percent[b]

Source: adapted from *TRICARE/CHAMPUS User's Guide*, Special Section in *Army Times*, *Navy Times*, *Air Force Times*, March 8, 1999.

a. Figures in the table apply to active-duty family members only. For active-duty sponsors, care is generally available at MTFs only. All such care is free, except for an $8.00 daily subsistence fee during inpatient stays at MTFs.

b. Percentages are applied to the CMAC. In addition, for nonparticipating providers, beneficiaries pay the excess above the CMAC; however, providers are forbidden by law from charging more than 115 percent of the CMAC.

c. Percentages are applied to the negotiated amount, which is less than the CMAC.

Complicating cost strategies

Over the history of the contemporary military health care benefit, the Department of Defense has made numerous program changes aimed at containing overall program costs. Some of these changes have limited beneficiary freedom to choose between the direct care system and CHAMPUS. Other changes have influenced beneficiary copay levels and the manner in which provider reimbursement levels are determined and paid. The unintended effect of these policies, however, is complication of the billing and claims resolution process.

Precertification of certain types of care is a common cost and quality control mechanism required by health insurance plans for hospitalization and certain other types of care. The military has its own system of precertification, known as a statement of nonavailability, which precertifies beneficiaries for CHAMPUS coverage for certain types of care. Over the years, inconsistent application of the requirement and changes to its underlying rules have served as a source of confusion for beneficiaries.

Before the implementation of TRICARE, eligible military beneficiaries who use the military health care benefit as their primary source of insurance have been free to choose where they receive their outpatient care for each point of service: either the military direct care system or civilian providers under CHAMPUS coverage. For inpatient care, if a beneficiary lived within a 40-mile radius of the local MTF, he or she first had to attempt to obtain care at the MTF. If he or she could not receive care at the MTF because of space or resource constraints, the local MTF commander would issue a nonavailability statement[10] authorizing CHAMPUS coverage of civilian inpatient care. For obstetrical care, the MTF had to be able to provide all prenatal, delivery, and postnatal care; otherwise, the beneficiary would receive one NAS authorizing CHAMPUS coverage of all obstetrical care from a civilian provider. In cases of emergencies or care received outside the catchment area, the NAS requirement was waived. Also, in cases,

10. Referred to originally as a "Medicare permit," Congress changed the name of the form to statement of nonavailability in 1966 after creating the federal Medicare program [16].

where the beneficiary has some other source of health insurance and uses CHAMPUS as a second payor, no NAS is required.

The concept and use of the NAS dates to 1960, early in the years of the history of the benefit [46]; Congress added the formal definition of the catchment area in 1976 [19]. Before 1976, each military service had the discretion of defining the geographic area comprising each local military health care facility's normal service area. As of the 1976 legislation, Congress specifically prohibited the use of CHAMPUS payments for nonemergency inpatient care at civilian facilities when treatment was available at the local MTF and the beneficiary lived within a 40-mile radius of the facility.

Imposition of the NAS rule, however, has been mostly at the discretion of the MTF. In cases where the MTF does not have the resources to provide certain types of specialty care, issuance of the NAS is an easy, straightforward, uniform decision. In other cases, the MTF may have the resources to provide the specialty care, but patient demand for the care outweighs the MTF's ability to supply it in the time required. One specialty area in which demand frequently exceeds MTF capacity to provide it is obstetrics for normal pregnancies. In cases where the medical condition cannot wait for care (or space) to become available at the MTF, the military provider issues an NAS authorizing CHAMPUS coverage of civilian care. Finally, military physicians sometimes issue an NAS for inpatient care even when the MTF is able to provide it because the beneficiary already has an established relationship with a civilian doctor and expresses a preference for receiving their inpatient care from that doctor. In these instances, maintaining patient continuity of care between patient and physicians took precedence over optimizing use of MTF resources.

Under TRICARE, Prime enrollees do not have to obtain an NAS for outpatient or inpatient care; however, their assigned PCM coordinates their care and completes care authorization forms for referrals. TRICARE extra and standard users still must obtain an NAS from the MTF for coverage of civilian inpatient care. The use of NASs as they relate to maternity care has been revisited as an issue several times under TRICARE. Originally, maternity patients not enrolled in Prime were required to seek all their obstetric-related care first at the MTF.

If space was not available, the MTF issued one NAS authorizing TRICARE standard coverage for the entire episode of care. Beginning in FY 1997, Congress changed the provision to require an NAS for the inpatient delivery only, but did not require the NAS for outpatient prenatal and postnatal care [24]. This change complicated the process of receiving OB care by separating the care into two parts: outpatient pre- and post-natal care, and the inpatient delivery. MTFs that had the space available to provide the inpatient delivery were faced with a difficult dilemma. The MTF could risk making the beneficiary unhappy by not issuing the NAS and requiring her to deliver at the MTF, or the MTF could issue the NAS, keep the patient happy, and fail to optimize MTF resources. Congress reversed to the original rules on maternity-related NASes in FY 2000. Once again, beneficiaries need one NAS requirement for the entire episode of care, effective for all maternity care initiated on or after 5 October 1999 [47].

In addition, the Assistant Secretary of Defense (Health Affairs) had imposed the NAS requirement on selected outpatient surgical procedures listed in table 11, effective as of 1 October 1991 [48]. This action followed a general surgical practice shift by physicians performing certain procedures to the outpatient arena during the 1980s. Consequently, for certain types of outpatient care, beneficiaries no longer chose freely between the local military and civilian providers. Under TRICARE, DOD rescinded the NAS requirement for the outpatient surgical procedures at the end of FY 1996 [49]. Even though the NAS is no longer required for the surgical procedures listed in table 10, all TRICARE eligibles must receive advanced approval from the regional TRICARE contractor for these services, plus the following three: cardiac catheterization, laparoscopic cholecystectomy (gall bladder removal), and magnetic resonance imaging (MRI).

With respect to provider reimbursement strategies, DOD reimbursed civilian providers on the basis of reasonable billed charges for nearly the first 20 years in which the military health care benefit covered such care. To contain growth in program costs, Congress limited CHAMPUS payments in fiscal year 1978 to no more than the 75^{th} percentile of the usual, customary, and reasonable (UCR) payment for similar services in the same locality where medical care was furnished [50]. One year later, Congress adjusted the CHAMPUS maximum allowed cost (CMAC) to no more than the 80^{th} percentile [51]. As

noted earlier, DOD shifted to the use of the DRG-based payment system for inpatient care under CHAMPUS beginning in FY 1988 and for inpatient care at the MTFs for third-party payment purposes beginning FY 1995. However, DOD continues to use the CMACs for outpatient services covered under TRICARE standard, and the CMACs serve as the baseline from which DOD negotiates rate discounts for network providers under the TRICARE regional managed care support contracts. When a provider accepts assignment of the TRICARE rates, the beneficiary using TRICARE standard coverage has lower copay levels. If a provider does not accept assignment, the beneficiary is responsible for payment of the amount above the TRICARE rate.

Table 11. Outpatient surgical procedures requiring NAS authorization, effective 1 October 1991 through 23 September 1996

Procedure
Gynecological laparoscopy
Cataract removal
Gastrointestinal (GI) endoscopy
Myringotomy or typanostomy
Arthroscopy
Dilation and curettage (D&C)
Tonsillectomy and adenoidectomy
Cystoscopy
Hernia repairs
Rhinoplasty and septoplasty
Ligation or transection of fallopian tubes
Strabismus repair
Breast mass or tumor removal
Neuroplasty

Some military beneficiaries have other primary sources of health insurance coverage, not including Medicare coverage. In general, it is more common for retiree families than active duty families to have some other source of primary health insurance coverage. For example, in FY 1997, about 55 percent of retirees and their families not enrolled in TRICARE Prime had some other source of primary health insurance compared to 18 percent of active duty families not enrolled in Prime [53]. Persons with other health insurance coverage may

choose not to use their military health care benefit. Or they may use CHAMPUS (TRICARE standard) as a second payer for their civilian-based care. CHAMPUS has provided supplemental (secondary) coverage to other health insurance plans paying at least 75 percent of the covered services since 1983 [54]. Alternatively, Congress also has authorized the MTFs to bill a beneficiary's other health insurance when the beneficiary chooses to receive their care in the MTF [42, 55]. DOD implemented third-party billing for MTF inpatient care in FY 1988 and for outpatient care in FY 1993.

Why do these various requirements and strategies complicate the billing and claims process? Care precertification, rate assignment, and multiple third-party payers are all techniques used under other health insurance plans. Claims processors are familiar with these mechanisms, and so are health care providers. What is the complicating factor? Does DOD clearly provide claims processors with the information they need to process claims correctly? Do they furnish health care providers with proper billing information? Do the beneficiaries understand their benefit? Does DOD do an effective job of providing soldiers, sailors, airmen, and Marines with education and marketing information? Does the military culture somehow impede beneficiaries from taking on the responsibility of knowing about their health care benefit? We do not have ready answers for these questions. They clearly require study beyond the scope of this research. We offer them here to provoke thought.

The cost of change

In this section, we identify what we believe represent the major changes to the military health care benefit since 1956 and examine their relative impact on military health care benefit program costs. The changes that we focus on are the following:

- 1967, implemented the Military Medical Benefits Amendments of 1966
  - — Formally established the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), including coverage for retirees and their dependents
  - — Expanded MTF and civilian provider coverage
- 1977, introduced the 40-mile radius catchment area rule
- 1978, capped CHAMPUS reimbursement levels to no more than 75 percent of the usual, customary, and reasonable (UCR) charges for a given service within a specified geographic area
- 1983, authorized CHAMPUS as secondary payer
- 1987, implemented Dependents' Dental Program
- 1988, made changes to provider reimbursement methods
  - — Implemented CHAMPUS DRGs
  - — Began MTF third-party billing for inpatient care
- 1988-89, established catastrophic cap1988
- 1995-98, changed to TRICARE.

The introduction of CHAMPUS in 1967 marks the complete definition of the military health care benefit in terms of the traditional system of health insurance that widely came into being in the United States during the 1950s and 1960s. The switch to TRICARE from 1995

through 1998 marks the transition to a system of managed care following similar transitions in the U.S. health care market during the 1980s and 1990s. The addition of the Dependents' Dental Program marks an expansion of covered services in the military health care system that we believe holds the greatest potential for increasing program costs. The authorization of CHAMPUS as a second payer and the establishment of the catastrophic cap provide relief to beneficiaries in terms of their out-of-pocket costs. The remaining changes represent cost containment strategies aimed at controlling beneficiary utilization of certain services or provider reimbursement levels under CHAMPUS coverage.

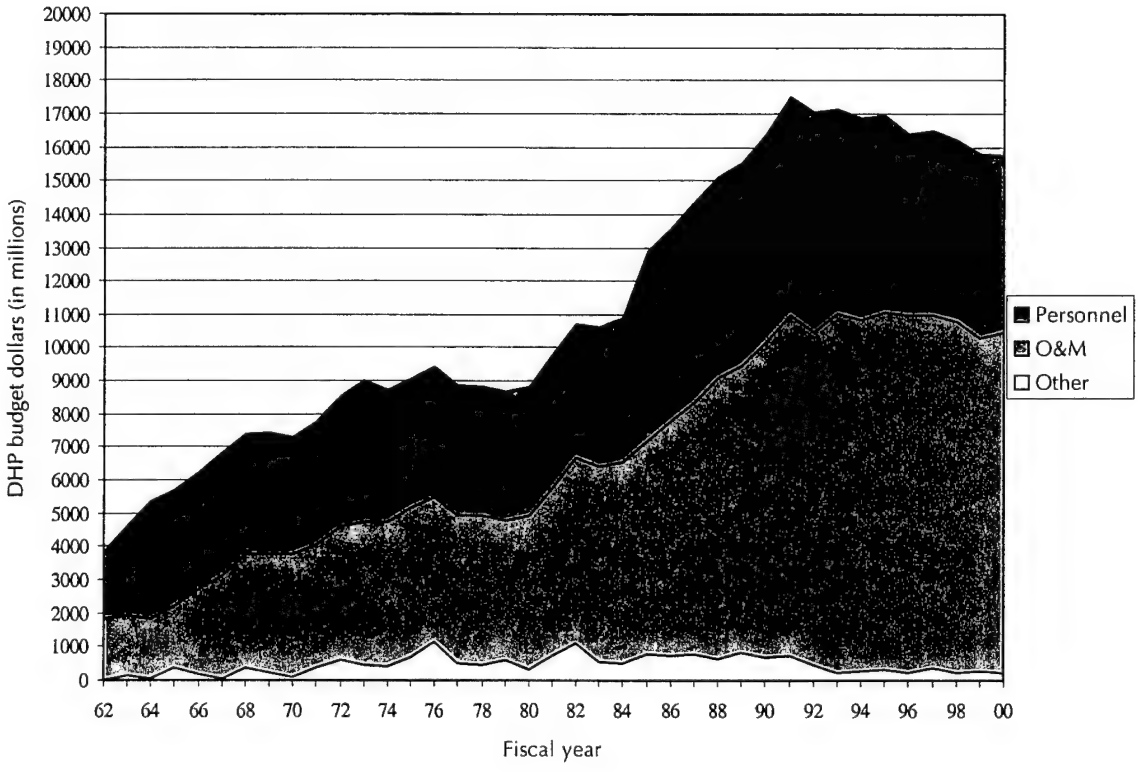
Ideally, to conduct our analysis of Defense Health Program costs, we would like to have data for program costs, the number of user beneficiaries, and utilization patterns from 1957 through 2000. Unfortunately, DOD does not have detailed data on the military health system's costs and utilization covering the full historical timeline of the benefit. The most extensive time series data available reflecting Defense Health Program costs are budget data for FY 1962 through 2000. We extracted these data from the 1962 through 2000 Historical FYDP, DOD Planning, Programming, and Budgeting System (PPBS) data produced by the DOD, Office of the Director, Program Analysis and Evaluation. We chart the DHP budget totals from 1962 through 2000 in figure 4. We express these data in 1999 dollars using the DOD deflator series.

Ideally, we would like to model the DHP budget series taking all these different variables into consideration. We also need to take into account the number of people using the military health care benefit and their relative resource consumption over time. Unfortunately, as noted above, DOD has not archived historical data on the number of user beneficiaries and their relative consumption of health care resources. In addition, we cannot statistically untangle at the DHP budget level the individual effects of changes in the benefit and other events occurring over time. Consequently, we attempt to draw insights from a cursory examination of the military medical departments' historical budget data, simple calculations of the cost per user beneficiary from fiscal year 1984 to year 2000, and a look at CHAMPUS utilization

and expense data from fiscal year 1998 which are the most recent data available.

We begin by examining the raw time series data in figure 4 to determine obvious changes in the budget that may correspond with one of the eight major benefit changes that we identified above. The first event of interest is the introduction of CHAMPUS coverage in 1967. Our expectation is that we would observe an increase in overall program costs in 1967, perhaps followed by further significant growth in 1968. During the period, we do observe a general upward trend in the DOD health budget. Personnel costs seem to be on a general increase throughout the 1960s and O&M costs begin a dramatic rise in 1965. However, these increases also follow the Gulf of Tonkin Resolution in 1964 and corresponding escalation of U.S. military involvement in the Vietnam Conflict.

Figure 4. DHP budget (in 1999 dollars using the DOD deflators), FY 1962-2000



The next set of changes occurs during the mid- to late-1970s. In 1977, military medicine introduced the catchment area rule, and in 1978 Congress capped CHAMPUS reimbursement levels to no more than 75 percent of the usual, customary, and reasonable (UCR) charges for a given service within a specified geographic area. The first change focused on containing CHAMPUS admissions in areas in which MTFs have the capacity to provide the needed inpatient care. The second change aimed at containing civilian provider reimbursement levels under CHAMPUS. Following the implementation of these changes, the defense medical budget decreased and leveled off for a period of roughly 4 years.

During the 1980s, the military medical departments' budget increased significantly. A series of changes occurred over this time that most likely contributed to this dramatic increase, but do not account for it in total. In 1983, military beneficiaries with some other source of primary health insurance could begin to file claims for secondary coverage under CHAMPUS. In 1987, the Dependents' Dental Program was offered to beneficiaries; in 1988-89, beneficiary annual out-of-pocket costs were capped at a maximum catastrophic amount. Secondary coverage under CHAMPUS may have encouraged more beneficiaries to use the benefit and may have contributed to an increase in overall costs. The Dependents' Dental Program adds the costs of this new coverage to the overall benefit. A catastrophic cap for beneficiaries potentially translates to increased cost liability for DOD. DOD was able to achieve cost savings with the implementation of DRGs in 1988 [56]. However, these cost savings provided only slight relief to the system given other substantial increases in CHAMPUS mental health overall outpatient utilization and costs [57].

Other policy events of the 1980s also are relevant.[11] The Reagan administration achieved large budget increases in the Defense Department. Readiness was the focus of the decade. Under this build-up, the military medical departments were directed to develop, field, and staff a number of new medical contingency platforms to support forces in theater. For example, in the Navy, these new contingency platforms

11. We obtained the following information from [52].

include 21 fleet hospitals and 2 hospital ships. Congress funded additional billets to staff the military medical readiness requirements in 1985, providing an increase of nearly 25 percent to the defense medical departments' military personnel (MILPERS) budget dollars (see figure 5). However, we did not find a matching increase in authorized medical billets on the historical Navy billet file data archived at CNA. So, while the increase in MILPERS funding provided additional billets, it appears that these funds may have been diverted to support other DOD communities. Following this increase, MILPERS funding leveled off through the end of the decade. Concurrently, medical operations and maintenance (O&M) costs nearly doubled from 1980 to 1989. Direct care system costs increased by 50 percent over the period, while CHAMPUS costs increased by 150 percent (see figure 6). As a proportion of total medical O&M dollars, CHAMPUS consumed nearly half of all medical O&M funds in 1989, while the direct care system spent only a third of medical O&M dollars.

The transition to TRICARE is the final major change that we examine. DOD implemented the TRICARE program over a 3.5-year period from late 1995 through May 1998. From figure 4, we see that DHP costs have decreased somewhat since the implementation of the TRICARE program. However, the defense budget has been slowly decreasing during the 1990s following the end of the Cold War. Although TRICARE has had an impact on beneficiary use and costs [see 53], this impact has occurred within a more constrained budget environment for the Defense Department.

We also have data on the number of user beneficiaries for 1984 projected through 2000. We use these data to determine the cost per user beneficiary under the DHP from 1984 through 2000 (see figure 7). We find that the average cost of care for people using the system has increased from about $1,500 in 1984 to a projected cost of nearly $2,700 in 2000. Have the yearly increases been statistically significant and in the expected direction depending on the corresponding change in military benefit? The cost per user beneficiary steadily increases through the 1980s, with statistically significant increases occurring in 1984, 1985 1987, 1990, 1991, and 1992. The cost per beneficiary levels off during the remainder of the 1990s at $2,600 to $2,700. Can we reasonably attribute the growth in the cost per user beneficiary over the 1980s and first few years of the 1990s to the changes

Figure 5. Military Medical Department personnel budget dollars by major program, FY 1980-2000

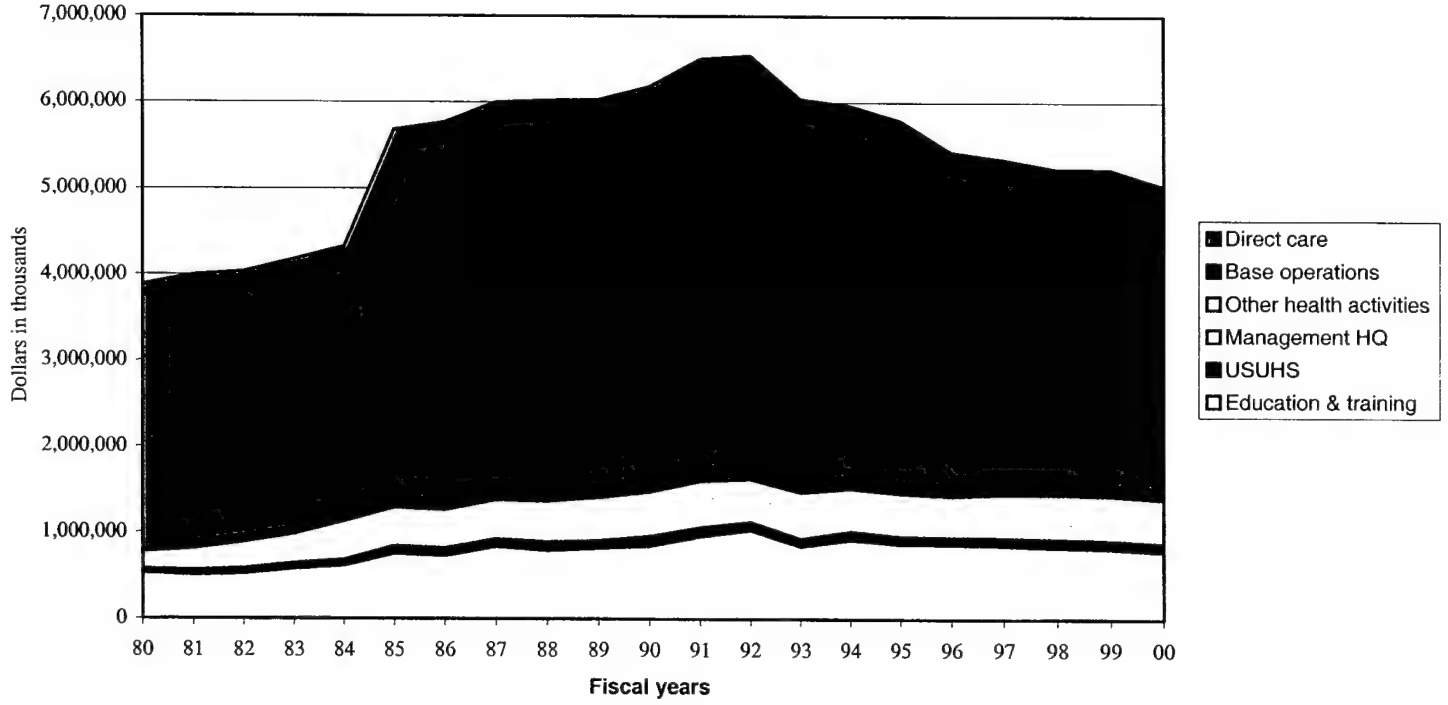
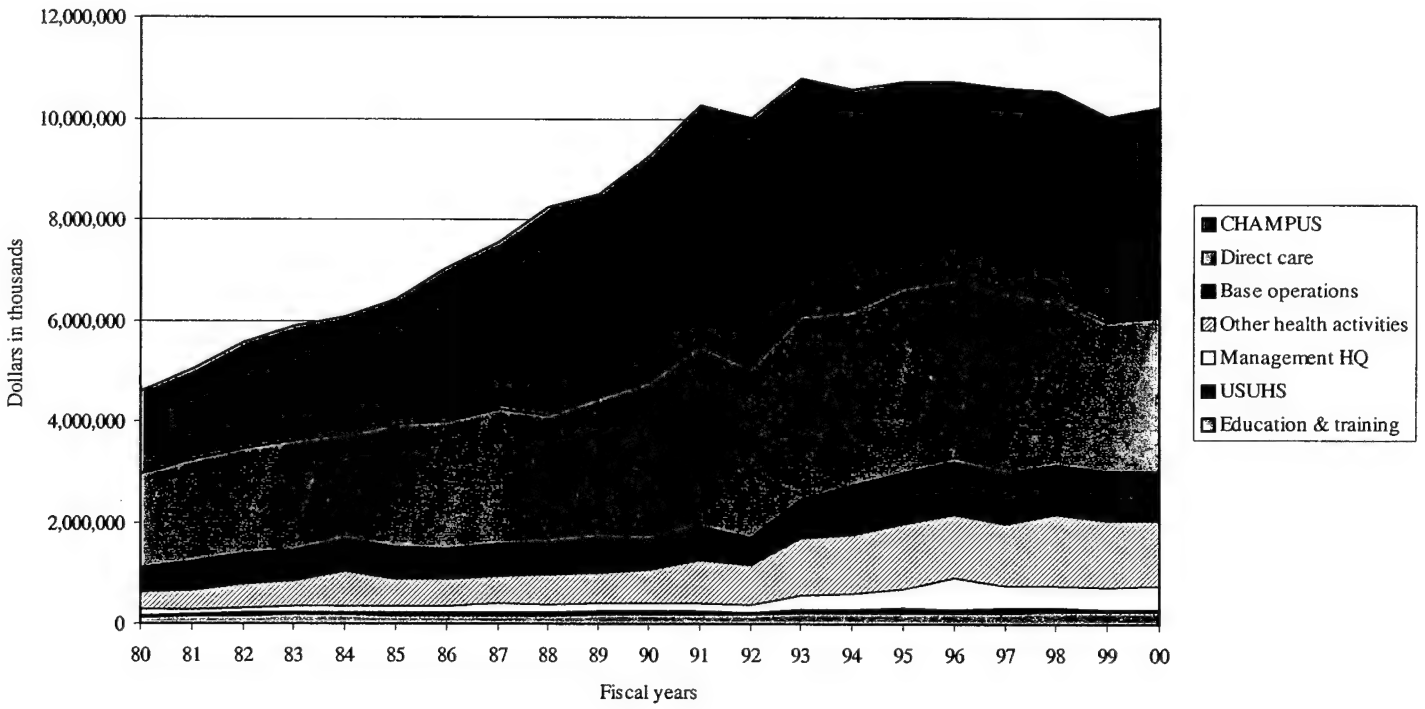
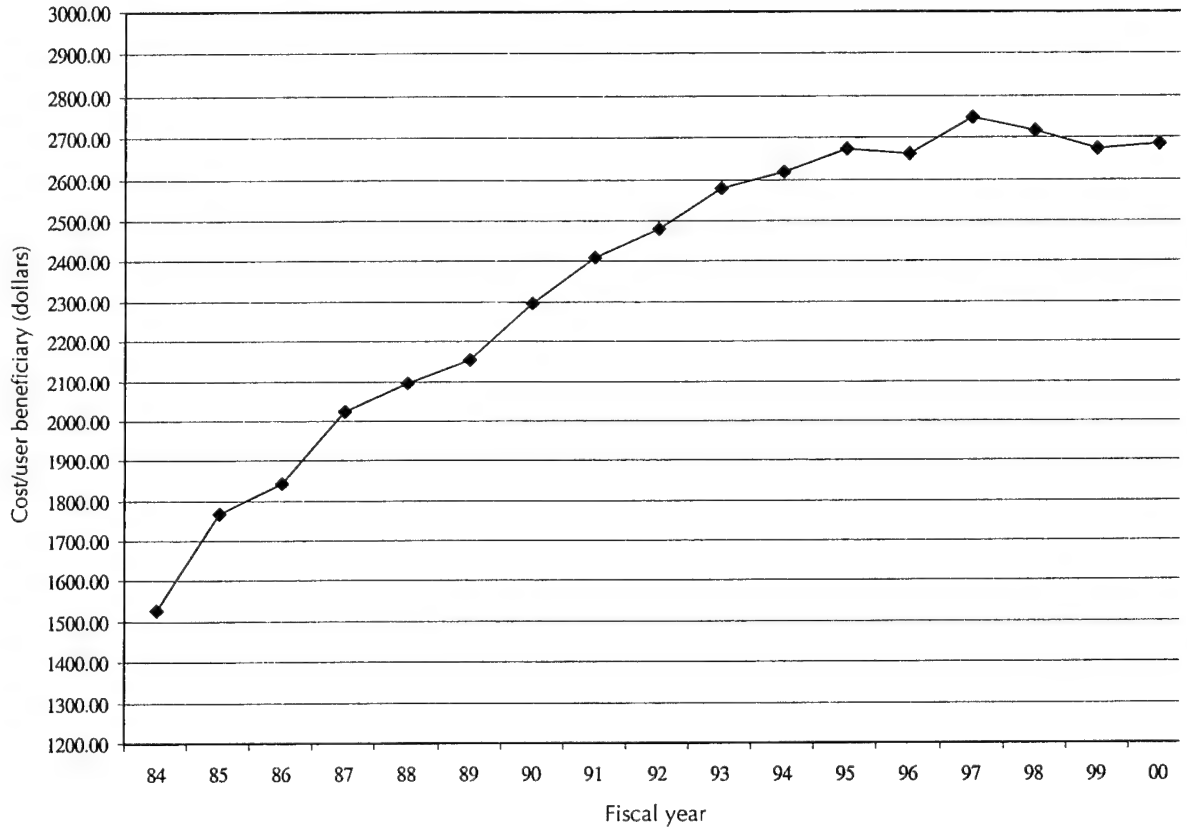


Figure 6. Military Health Care System operations and maintenance dollars by major program, FY 1980-2000



occurring in the benefit during that time or are there other contributing factors? Furthermore, is the more stable cost per user during the mid- to late-1990s entirely attributable to TRICARE? Perhaps the cost trends reflect the general budget pattern for DoD for the 1980s and 1990s.

Figure 7. DHP cost per beneficiary (in 1999 dollars using the DOD deflators), FY 1984-2000



Based on our analysis so far, we find it difficult to point to any one change that had an immediate, clear, singular impact on DOD's health program costs. Also, given the aggregate level of the budget data, it is difficult to identify the health-care-related elements of program costs. One trend that has plagued DOD throughout the 1980s and 1990s is the occurrence of large budget shortfalls for CHAMPUS. To determine whether any of the historical changes to the benefit are

significantly contributing to the military's bill for civilian-based care, we examine the most recent data available from FY 1998 on TRICARE/CHAMPUS expenditures and utilization. Overall, in FY 1998, the Department of Defense spent about $3.9 billion dollars (40 percent of total medical O&M dollars) to cover beneficiary expenses associated with health care from civilian providers [56]. About 3 percent of the expenses were associated with fiscal intermediary administrative costs ($48.3 million) and office costs for the TRICARE support Office ($56.3 million). While the remaining 97 percent ($3.8 billion) of these expenses were associated with benefit (medical care, dental, and mail order pharmacy) and managed care contract costs. Of the $3.8 billion, approximately $2.4 billion were associated with health service expenses, and nearly two-thirds of these expenses were associated with care for retirees and retiree family members. See table 12.

Table 12. Government TRICARE/CHAMPUS health services expense (in millions) by beneficiary category, FY 1998

Beneficiary category	Expense ($)	Percentage
Active duty family members	920.7	38.7
Retirees	521.5	21.9
Retiree family members	939.0	39.4
Total	2,381.2	100.0

Source [56]

Similar data for fiscal years 1996 and 1997 from [58] reflect a similar distribution in which retirees and their family members are associated with over three-fifths of TRICARE/CHAMPUS expenses. While we cannot necessarily attribute immediate reactions in beneficiary utilization behavior and costs with specific benefit changes in the short term, recent data on TRICARE/CHAMPUS expenses suggest a long-term impact on DOD health care program costs associated with the Congress's decision in 1966 to extend coverage to retirees and their dependents for civilian health care. Given the aging of the eligible population and longer life expectancies in the United States, it is likely that retiree demands for care will continue to make up a growing portion of total DOD health care costs.

Conclusion

The peacetime mission of the military health care system has expanded significantly since 1956, when Congress first authorized the offering of civilian health care coverage to active duty dependents. During the past 44 years, changes have affected who is eligible for care under the benefit, what services are covered under the benefit, and how much the benefit costs in terms of costs to the beneficiary and provider reimbursement strategies. These changes have been both of minor and major consequence for the military health care benefit.

The benefit in the year 2000 provides eligible beneficiaries with broad, comprehensive coverage of medical, surgical, and mental/behavioral health care. Structurally, Congress directed the Defense Department to follow civilian health care market trends in developing the benefit. For over three decades, the military health care benefit looked much like the traditional, indemnity plan, which predominated the civilian market. During the past decade, the military health services system has transitioned to a system of managed care, once again following the predominant benefit plan offered in the civilian market.

In terms of costs, beneficiary out-of-pocket payments have remained about the same over time and at low levels. The same has not been true for the Defense Department, which has experienced significant growth in payment levels for its military health care program. How have the changes to the benefit contributed to this growth? We identified a number of changes that we felt held the greatest potential to impact Defense Health Program costs over time. Most of these changes were reimbursement strategies focused on directing beneficiaries into the MTFs for their care and on containing civilian provider payment rates. Their relative influence appeared tenuous and temporary, at best. The definition of who is eligible for care in the MTFS has not changed dramatically since 1956 and the expansion of

covered services under CHAMPUS has followed market trends and medical technology advancement.

One change has had a significant impact on military health program costs, though it was not immediate. The change was the extension of the retiree health benefit to include CHAMPUS coverage in 1966. The military services in the year 2000 face the same dilemma as the civilian sector: covering the health care costs of an aging beneficiary population whose life expectancy has increased. During the 1980s and 1990s, the majority of the distribution of eligible beneficiaries shifted slowly from the younger and healthier active duty members and their families to favor the older retirees and their families. These beneficiaries also are more likely to require medical care at greater expense to the system. Health care expenses for retirees and their families consistently represented two-thirds of the CHAMPUS bill during the late 1990s. This trend is not likely to change, particularly if Congress grants military Medicare-eligible beneficiaries increased levels of coverage in the military health care system.

Appendix: The Uniformed Services Family Health Plan

The Military Construction Authorization Act of 1982, section 911 (42 U.S.C. 248c), designated 10 currently civilian owned, former Public Health Service hospitals as Uniformed Services Treatment Facilities (USTFs). These facilities were subsequently incorporated into the military health care system. Any eligible beneficiaries of the military health care system, with the exception of active duty personnel, were permitted to enroll in the USTFs. Upon enrollment, beneficiaries agreed not to use any other health care sources within the military or Medicare systems. The USTFs provided health care to enrolled beneficiaries subject to individual participation agreements negotiated by the Department of Defense on behalf of itself and the Department of Health and Human Services and Transportation [10].

The fate of the USTFs was also addressed in the 1991 Authorization Act. The effective date of termination for these facilities was changed from 1990 to 1993. The act also established a financial limitation of $154 million on the cost of these facilities. Finally, the Secretary of Defense was directed to finalize negotiations with the USTFs and begin to implement a managed care delivery and reimbursement model that will continue to use the USTFs in the military health care system.

The 1996 Defense Authorization Act had an impact on the Uniformed Services Treatment Facilities. The act mandated that the relationship between the USTFs and the Department of Defense be subject to the FAR with full and open competition for the contracts. It also stipulated the development of a plan for the integration of the USTFs into the TRICARE system. Finally, it established that the USTFs had to adopt the TRICARE enrollment fees and copays [10].

The incorporation of the USTFs, otherwise known as the designated providers, into the military health care system was finally established by the 1997 Defense Authorization Act. An agreement was to be negotiated with each designated provider for the provision of health care services through managed care plans to eligible beneficiaries who chose to enroll with the designated provider in question. The health care services provided by a designated provider were to be on a "full risk capitated payment basis," which would be based on enrollees' utilization experiences and current competitive rates for equivalent services provided to similar populations. The payments could not exceed the expected costs incurred by the government if these health care services were provided at MTFs.

The USTFs were incorporated into the military health care system as an alternative to the TRICARE Prime option known as the Uniformed Services Family Health Plan (USFHP). The USFHP provides comprehensive medical coverage including major medical expenses, preventive care, and prescription drugs. The USFHP option is available to the following beneficiaries:

- The dependents and spouses of active duty members of the military
- Military retirees and their dependents, including those over the age of 65
- Eligible surviving family members of active or retired members of the military who are deceased.

The USFHP option is available in only seven areas of the country: Seattle, WA; Portland, ME; Brighton, MA; Staten Island, NY; Baltimore, MD; Cleveland, OH; and Houston, TX. Enrollment in the USFHP is contingent on residing in one of these seven locations and on the availability of space in the program. While active duty families can enroll in the plan throughout the year, retirees and their dependents are eligible to enroll only during the open enrollment period that is held in the spring for a period of 30 days. Enrollment in the USFHP involves a commitment of 1 year to receive care through the plan unless a change occurs to the eligibility status of the beneficiaries or they are no longer residing in the required location [13].

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